No. 88-1659 (4)

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,
Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,
Respondent.

AMICUS CURIAE BRIEF IN SUPPORT OF PETITIONERS (PURSUANT TO CONSENT OF THE PARTIES)

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AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS THEODORE KANNE AND BEATRIZ KANNE

INTRODUCTORY STATEMENT

Pursuant to the consent of the parties, copy of which is annexed hereto as Appendix "A," the undersigned Amicus Curiae, the California Medical Association, respectfully submits this

Brief in support of Petitioners, Theodore and Beatriz Kanne. [1] The undersigned is concerned with the present case because ERISA preemption threatens the welfare of the patients of its members. As will be detailed below (Point I, infra), the State of California has enacted numerous laws aimed at protecting

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1. The undersigned has previously moved this Court for leave to file an Amicus Curiae Brief in Juliano v. Commercial Life Ins. Co., No. 88-1530. The same considerations set forth therein apply to the instant case.

Additionally, however, the instant case presents an issue not presented in Commercial Life: the issue of what are the criteria which will establish that an insurance arrangement is an "employee benefit plan" subject to the Employee Retirement Security Act (ERISA) under 29 U.S.C. Section 1003, and related issues (see Questions Presented in the Kannes' Petition for Writ of Certiorari in the instant case at pp. i-iv).

The common issue in Commercial Life and the instant case is the issue of whether ERISA bars plaintiffs from securing state law remedies afforded by a state law which regulates insurance, specifically, California Insurance Code Section 790.03(h)(2).

and regulating health care. We believe that it is absolutely essential to the welfare of our patients that these laws remain in full force and effect. Their enforceability and effectiveness should not be diluted or delayed by questions concerning whether the federal law of ERISA may impact upon them in some manner.

ARGUMENT

I

IT WAS NOT THE INTENTION OF CONGRESS TO DESTROY THE SAFEGUARDS AND PROTECTIONS AFFORDED BY STATE LAW FOR THE BENEFIT OF THE VERY PERSONS CONGRESS INTENDED TO PROTECT BY ENACTING ERISA.

ERISA was not enacted in order that the federal government regulate the payment of insurance claims and other health benefits. It is not designed to police the prompt payment of legitimate

insurance claims, and did not even contemplate this problem.

Thus, ERISA permits insurers to delay or deny claims with impunity. Under ERISA, an insurer who wrongfully denies payment of a claim is required only to pay what the insurance policy required it to pay in the first place and attorneys' fees in the discretion of the Court. 29 U.S.C. Section 1132(g). And there is no requirement at all that claims be paid promptly. Under ERISA regulations, an insurance company may delay any decision as to whether to pay a claim for up to 300 days. 29 CFR Section 2560.503-1(e)(1)(3); Section 2560.503-1(h). Even if an insurer in fact violates this 10-month provision, it is not subject to any penalties, even the ineffective ERISA penalties. Insofar as we are aware, there is no provision in

the statute or the regulations requiring prompt payment of a claim even if it is not denied or contested. See 29 U.S.C. Section 1132; 29 CFR Section 2560.503-1.

We do not believe that the health care system in California can withstand a great number of delays in payment for such inordinate lengths of time, even if payment is ultimately made. [2] Because of the large number of employees in California dependent on ERISA employee benefit plans to pay their bills, the potentially catastrophic effect of ERISA preemption is self-evident, and cannot

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2. The type of abuses that are threatened is demonstrated by the facts of the instant case. See petitioners' petition at pp. 5-12, opinion of the District Court, Kanne v. Connecticut General Life Ins. Co., 607 F.Supp. 899 (C.D. Cal. 1985).

seriously be denied. [3]

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3. The primary mechanism for enforcing the prompt payment of legitimate claims in California has been the private right of action for breach of the California Insurance Unfair Claims Practices Act, Ins. C. Section 790.03(h). The California Supreme Court has now prospectively abolished this private right of action. Moradi-Shalal v. Firemen's Fund Ins. Cos., 46 Cal. 3d 287, 758 P.2d 58 (1988). However, the California Supreme Court made it clear that the Legislature has the power to reinstate the private right of action. Moradi-Shalal, supra, 46 Cal. 3d at p. 305, 758 P.2d at p. 69.

The opinion of the Ninth Circuit Court of Appeals in the present case holds that ERISA preempts such private rights of action. Hence, if permitted to stand, the present opinion will bar the State of California (and, of course, the 49 other states as well) from ever authorizing a private right of action which can be asserted against insurers of ERISA plans. This will drastically limit the traditional power of the states to curb claims abuses through private rights of action--the most effective method of doing so.

Whether ERISA preemption will affect the states' ability to curb such abuses through criminal and administrative action is an open question not ruled upon by the Ninth Circuit in the present case. See Appendix to Petition, Appendix D at p. D-80.

Nor is our concern over ERISA preemption addressed solely to California Insurance Code Section 790.03(h), the statute at issue in the present case. Numerous other beneficial and protective California laws regulating insurance and other health care services are also threatened by a broad interpretation of ERISA preemption. Some of these laws include the following:

1. Provisions prohibiting insurers from discriminating between individuals because of race, color, religion, national origin or ancestry. California Insurance Code Sections 10140, 10141;

2. Provisions prohibiting less favorable terms to employees in group disability insurance plans than to their spouses. California Insurance Code Section 10122.2. See also California Insurance Code Section 10123.4; Health

and Safety Code Section 1374;

3. Provisions prohibiting discrimination against physically handicapped persons. California Insurance Code Sections 10123.1, 10123.2; Health and Safety Code Section 1373(f);

4. Provisions prohibiting discrimination against persons carrying a gene which causes no adverse effects in the carrier. California Insurance Code Sections 10123.3, 10143, 11512.95; Health and Safety Code Section 1374.7;

5. Provisions barring exclusion of victims of Alzheimer disease or other dementing illnesses from receiving benefits or other coverage. California Insurance Code Sections 10123.16, 10123.17, 11512.177; Health and Safety Code Section 1373.14;

6. Provisions barring group disability insurers and health care

service plans from discriminating against the blind. California Insurance Code Section 10145; Health and Safety Code Section 1367.4;

7. Provisions preventing insurers from controlling the patient's selection of a hospital or physician. California Insurance Code Section 10133;

8. Provisions that health care service plans and hospital service plans which affect a patient's freedom of choice in selecting physicians or hospitals must clearly so inform the patient. California Insurance Code Sections 10123.12, 11512.176; Health and Safety Code Section 1367.10;

9. Provisions requiring health care service plans (which restrict the patient's freedom of choice of providers) to follow a variety of procedures to insure access to quality medical care.

Health and Safety Code Sections 1368, 1369, 1370; 10 Cal.Admin. Code Sections 1300.6, 1300.68, 1300.70;

10. Provisions requiring that facilities providing the primary health care services of a health care service plan must be located within reasonable proximity of the business or personal residences of enrollees, that the hours of operation and provisions for after-hour services must be reasonable and that emergency health care services must be available and accessible within the service area 24 hours a day, seven days a week. 10 Cal.Amin. Code Section 1300.67.2;

11. Numerous provisions mandating that entities providing coverage for health care provide certain benefits, as well as coverage for dependents of the insured or plan participant. Some

examples of mandates include the following:

a. Requirements that coverage continue for certain dependents upon the attainment of the limiting age for dependency. California Insurance Code Sections 10277, 10278, 10124; Health and Safety Code Section 1374;

b. Requirements of coverage for newborn infants or newly adopted children. California Insurance Code Sections 10119, 10121(b), 11512.1; Health and Safety Code Section 1373;

c. Coverage requirements for maternity benefits. California Insurance Code Section 10119.5, 10121(c), 11512.13; Health and Safety Code Section 1373.4;

d. Coverage for conditions attributable to diethylstibestrol or exposure to it. California Insurance Code Sections 10119.7, 11512.195; Health

and Safety Code Section 1367.9;

e. Coverage requirements for diabetic daycare self-management education programs. California Insurance Code Sections 10177.7, 11512.23; Health and Safety Code Section 1367.5;

f. Coverage requirements for home health care. California Insurance Code Section 11512.20; Health and Safety Code Section 1374.10;

g. Coverage requirements for mental or nervous disorders. California Insurance Code Sections 10125, 10127, 11512.5; Health and Safety Code Section 1373(h);

12. Provisions requiring that coverage must be extended 12 months after discontinuance of a plan or policy for expenses relating to any condition causing total disability. California Insurance Code Sections 10128, 10128.2;

Health and Safety Code Section 1399.62;

13. Provisions to insure that providers of health coverage extend coverage following the termination of the employment of an employee. California Insurance Code Sections 10122, 10123, 11512.1; Health and Safety Code Section 1373;

14. A provision prohibiting a policy of insurance or health plan providing for loss of time benefits to contain any provision for a reduction of those benefits during a benefit period because of an increase in benefits payable under the Federal Social Security Act. California Insurance Code Section 10127.1; Health and Safety Code Section 1373;

15. Perhaps most importantly, California law requires reimbursement of covered expenses no later than 30 days

after receipt of the claim, unless a claim or portion thereof is contested. California Insurance Code Sections 10123.13, 11512.180; Health and Safety Code Section 1371.

The foregoing constitute only some of the laws of California aimed at protecting those California citizens who may have medical problems requiring the services of physicians and hospitals. We respectfully submit that Congress had no intention whatever of permitting the provisions of ERISA to nullify any of the foregoing statutes. It is clear that ERISA was established for the primary purpose of safeguarding employee pension plans, and was addressed to the problem that many pension plans relied on by employees for retirement income were rendered insecure and illusory by various questionable practices by the people

administering the plans. See, e.g.: Massachusetts v. Morash, ____ S.Ct. ____ (No. 88-32) (filed April 18, 1989); California Hospital Ass'n v. Henning, 770 F.2d 856, 859 (9th Cir. 1985), mod., 783 F.2d 946 (1986), cert. den., 477 U.S. 904 (1986). This purpose had nothing whatever to do with the issue of enforcement of fair claims practices or of the other laws set forth above. Nor is there anything in the Congressional findings and declarations of policy even remotely reflecting a Congressional intention to preempt state laws aimed at protecting beneficiaries of medical, hospital or disability insurance contracts, or state laws otherwise protecting the sick and disabled. To the contrary, the statute plainly and explicitly states that the "well-being and security of millions of employees and

their dependents" is the primary purpose of ERISA. 29 U.S.C. Section 1001, subdivision a. See also 29 U.S.C. Section 1001a, subdivision (a) (3) and 29 U.S.C. Section 1001b, subdivision (a) (2). This purpose would clearly be defeated by permitting ERISA preemption to prevent the States from affording state remedies to the very persons ERISA was designed to protect.

II

THIS COURT SHOULD RESOLVE THE ISSUE OF THE CIRCUMSTANCES WHEN AN INSURANCE ARRANGEMENT IS A PLAN GOVERNED BY ERISA.

We respectfully submit that an insurance arrangement which is not part of a written plan purposefully established as an ERISA plan should not be considered an ERISA plan. In Massachusetts v. Morash, supra, this Court held that an arrangement for

vacation benefits payable out of an employer's general assets did not constitute an ERISA plan. As noted above, this Court pointed out that Congress' primary concern in enacting ERISA was with the mismanagement of funds accumulated to finance employee benefits. This Court said that where a separate fund is not created to guarantee the payment of benefits the arrangement is not an ERISA plan. This Court also pointed out that extension of ERISA to claims for vacation benefits "would vastly expand the jurisdiction of the federal courts." This Court also noted that the states have "traditionally regulated" the payment of wages, including vacation pay.

Each of these elements are present in insurance arrangements such as the arrangement in the case at bar. The

insurance premiums are not paid out of a trust created for that purpose. To extend ERISA to claims for delay or denial of payments, or to other claims arising out of state laws addressed to health care, would vastly expand the jurisdiction of the federal courts. And the states have "traditionally regulated" insurance claims handling and other laws relating to health care. We therefore respectfully submit that the principles of Massachusetts v. Morash should apply to determinations of whether insurance arrangements are ERISA plans. But regardless of which criteria are utilized, we respectfully submit that it is urgent that uniform criteria, which are plain and unambiguous, should be adopted and the current conflicts among the various courts should be resolved.

Conclusion

We respectfully submit that the Kannes' petition should be granted.

Respectfully submitted,

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APPENDIX A

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PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPPEALS
FOR THE NINTH CIRCUIT

CONSENT TO FILING OF BRIEF AMICUS CURIAE
BY THE CALIFORNIA MEDICAL ASSOCIATION

We, Petitioners Theodore Kanne and Beatriz Kanne and Respondent Connecticut General Life Ins. Co., who are all the parties to the above-entitled cause, herein consent, by our respective counsel

of record, to the filing of a Brief of an Amicus Curiae by California Medical Association, in support of the Petition for Writ of Certiorari of Theodore and Beatriz Kanne, Petitioners, pursuant to Rule 36 of the Supreme Court rules.

CONNECTICUT GENERAL LIFE INS. CO.

By: Theodore B Olson

DATED: May 15th, 1989.

THEODORE KANNE and BEATRIZ KANNE

By: Leonard Kaden

DATED: May 10, 1989.